NAVIGATING YOUR STATE HEALTH BENEFIT PLAN

Retiree Decision Guide 2011

RETIREE OPTION CHANGE PERIOD
OCTOBER 12 – NOVEMBER 10, 2010

Georgia Department of Community Health

Phone Numbers/Contact Information

State Health Benefit Plan (SHBP): www.dch.georgia.gov/shbp

Vendor	Member Services	Website
CIGNA HRA, HMO, HDHP hours 8 am – 8 pm local time zone; Monday – Friday	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
Humana Group Medicare PPO Plan (An Alliance with CIGNA) Retiree Help Line hours 8 am – 8 pm local time zone; Monday – Friday	800-942-6724 TDD 800-576-1314	www.humana.com/stateofga www.mycigna.com/shbp
UnitedHealthcare Retiree Help Line Definity HRA HMO, HDHP hours 8 am – 8 pm local time zone; 7 days a week, TTY 711	877-246-4190 800-396-6515 877-246-4189	www.uhcretiree.com/shbp
SHBP Eligibility	404-656-6322 800-610-1863	www.dch.georgia.gov/shbp
Additional Information	**Member Services**	**Website**
Centers for Medicare & Medicaid (CMS) 24 hours a day / 7 days a week	800-633-4227 TTY 877-486-2048	www.medicare.gov
Social Security Administration	800-772-1213	www.ssa.gov

Disclaimer: The material in this booklet is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

Page 3 of this guide contains Plan changes effective January 1, 2011. Prior to the start of the 2011 Plan Year, or shortly thereafter, the Plan will post a new Summary Plan Description (SPD) for each Plan option to the DCH website, www.dch.georgia.gov/shbp. The SPD is your official notification of Plan changes effective January 1, 2011. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your SPD for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 1990, Atlanta, GA 30301-1990.

Georgia Department of Community Health

Clyde L. Reese, III, Esq., Commissioner Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

October 1, 2010

Dear State Health Benefit Plan (SHBP) Member:

Welcome to the 2011 Retiree Option Change Period (ROCP). This year the ROCP dates will be October 12 - November 10, 2010.

For Medicare-eligible retirees, SHBP is pleased to announce the introduction of Medicare Advantage (MA) Preferred Provider Organization (PPO) plans in 2011. The Centers for Medicare & Medicaid Services now require that all national Medicare Advantage (MA) Private Fee for Service plans (PFFS) offer members a provider network effective January 1, 2011. Therefore, the current MA PFFS options will be replaced with the MA PPO options.

Unfortunately, SHBP has not been immune to the state's budget reductions that affect the revenue coming into the health plan. Plan reserves have been diminished and as a result benefit adjustments and premium increases have been necessary to assure the financial stability of the plan. Early retirees (who do not have Medicare) will need to take action during ROCP. Simply go online and make your 2011 benefit selection or complete the 2011 Personalized Change Form (PCF) included in the Retiree Decision Guide Packet. Tobacco use and spousal surcharges may now be assessed to early retirees, so it is important to read about the surcharges in this guide and answer the surcharge questions.

SHBP is also impacted by the health care reform legislation that became law on March 23, 2010. While provisions of this Act will enhance your plan through expanded coverage for preventive care services and extended dependent coverage, these provisions have an impact on costs to the health plan in 2011. The costs of most of the health care reform provisions are being shared across the board by all members. Also, to accommodate the addition of newly eligible dependents, SHBP has now moved retirees from a two-tier to a four-tier structure.

As always, the Georgia Department of Community Health will continue to seek to provide you with cost-effective options and tools to help you make the best decisions for you and your family members.

Sincerely,

Clyde L. Reese, III, Esq.
Commissioner

Equal Opportunity Employer

Welcome to the Retiree Option Change Period (ROCP) for the State Health Benefit Plan for coverage effective January 1, 2011–December 31, 2011

The ROCP dates are October 12 through November 10, 2010. This guide will provide you with a brief explanation of each Plan option and information about changes that will impact all retirees. It is very important that you carefully read the Decision Guide before making your election for the 2011 Plan Year. This book, Plan rates and other information can be found at www.dch.georgia.gov/shbp or www.oe2011.ga.gov. To help you navigate the book, the Guide is divided into seven sections. This allows you to review only the sections that are applicable to your age and Medicare enrollment. Should you review all sections, it is suggested that you begin with Section 1, then the section that applies to your individual situation.

While CIGNA and UnitedHealthcare's basic plan design is the same for each option, each vendor has nuances in benefits and services that are unique to their option. It is important that you read the information you receive from both vendors so you will understand what these differences are and how they may affect you.

> Section 1 - Changes for all SHBP members

> Section 2 - Retiree Benefits when no one is eligible for Medicare

> Section 3 - What happens when I or a covered dependent become eligible for Medicare

> Section 4 - Retiree Benefits when I am, or a covered dependent is, eligible for Medicare

> Section 5 - Health & Wellness

> Section 6 - SHBP Eligibility

> Section 7 - Legal Notices

Be sure you review the Benefits Comparison charts on pages 8 - 11.

Table of Contents

>> SECTION 1 - Changes for all SHBP members

STOP!

IMPORTANT INFORMATION!

The changes listed below apply to all SHBP members.

- If you have a natural or adopted child or stepchild under age twenty-six, you are the legal guardian for a child under age twenty-six, or have a child who may meet the requirements of a totally disabled child, carefully read the new dependent eligibilty rules and decide whether to enroll the child in the SHBP. You have a one-time only chance during the 2011 Retiree Option Change Period to add dependent children who are now eligible under the new rules. Be sure to select a tier that includes children. The ROCP dates are October 12 – November 10. Coverage will be effective on January 1, 2011. For more information contact the SHBP Call Center at 404-656-6322 or 800-610-1863 or refer to pages 25-26 for SHBP eligibility definitions and rules.
- The life-time maximum benefit limit is being removed
- Wellness benefits have been expanded
- Pre-existing no longer applies to any of the SHBP plans
- There will be an increase in premiums
- The Open Access Plan (OAP) will no longer be offered
- If you are in the OAP, contact your health care vendor prior to December 31, 2010 to see if you qualify for transition of care (i.e. current treatments such as chemotherapy, certain scheduled surgeries, etc.)
- All SHBP members will receive new ID cards before January 1, 2011
- Retirees will now have four tiers just as active employees. They are:
  ■ You ■ You + Spouse ■ You + Child(ren) ■ You + Family*
- Tobacco surcharges have been increased to $80 per month and Spousal surcharges have been increased to $50 per month and apply to all options **except** the Medicare Advantage (MA) Options (see page 5 for information on how to have the surcharges removed)
- There are changes in co-pays, deductibles, out-of-pocket maximums, etc., as outlined below

*Family means you + spouse + children

HMO PLAN BENEFIT CHANGES		
Deductible	**2010**	**2011**
You	$600	$1,000
You + Spouse	Not applicable	$1,500
You + Child(ren)	Not applicable	$1,500
You + Family	$1,200	$2,000
Out-of-Pocket Maximum	**2010**	**2011**
You	$2,000	$3,000
You + Spouse	Not applicable	$4,500
You + Child(ren)	Not applicable	$4,500
You + Family	$4,000	$6,000
Specialist Office Visit	**2010**	**2011**
Co-payment	$35	$45
Pharmacy	**2010**	**2011**
Tier 1	$15	$20
Tier 2	$40	$50
Tier 3	$75	$90

Continued from page 3

HRA PLAN BENEFIT CHANGES		
Deductible	**In-Network/Out-of-Network 2010**	**In-Network/Out-of-Network 2011**
You	$1,100	$1,300
You + Spouse	Not applicable	$2,250
You + Child(ren)	Not applicable	$2,250
You + Family	$2,750	$3,250
Out-of-Pocket Maximum	**In-Network/Out-of-Network 2010**	**In-Network/Out-of-Network 2011**
You	$2,500	$3,000
You + Spouse	Not applicable	$5,000
You + Child(ren)	Not applicable	$5,000
You + Family	$5,700	$7,000

HDHP PLAN BENEFIT CHANGES				
Deductible	**In-Network 2010**	**In-Network 2011**	**Out-of-Network 2010**	**Out-of-Network 2011**
You	$1,200	$1,500	$2,400	$3,000
You + Spouse	Not applicable	$3,000	Not applicable	$6,000
You + Child(ren)	Not applicable	$3,000	Not applicable	$6,000
You + Family	$2,400	$3,000	$4,800	$6,000
Out-of-Pocket Maximum	**In-Network 2010**	**In-Network 2011**	**Out-of-Network 2010**	**Out-of-Network 2011**
You	$1,800	$2,400	$4,000	$5,300
You + Spouse	Not applicable	$4,100	Not applicable	$9,800
You + Child(ren)	Not applicable	$4,100	Not applicable	$9,800
You + Family	$3,100	$4,100	$7,400	$9,800

Impact of Health care Reform

Some changes for 2011 are the result of the Patient Protection and Affordable Care Act of 2010. The SHBP will now cover a member's child up to age 26, regardless of the child's marital, employment or student status, and regardless of whether the child lives with the member or is financially dependent on the member. The SHBP will now cover 100 percent of the cost of preventive treatments and screenings. The SHBP has eliminated all pre-existing condition requirements. The SHBP has eliminated all lifetime and annual limits for essential benefits.

Premiums for tiers that include dependent children have been increased to reflect the extra cost of covering newly eligible dependent children. However, the State continues to pay approximately 75 percent of the cost of coverage. The chart below shows the impact of the expanded dependent child coverage on premiums.

The rates below are for early retirees without Medicare.

	HRA			HMO			HDHP		
Employee Premiums	2010	2011	Expanded Dependent Coverage Cost	2010	2011	Expanded Dependent Coverage Cost	2010	2011	Expanded Dependent Coverage Cost
You	$62.50	$68.74	N/A	$100.20	$110.22	N/A	$54.40	$59.84	N/A
You + Spouse	N/A	$210.10	N/A	N/A	$260.14	N/A	N/A	$194.14	N/A
You + Child(ren)	N/A	$215.16	$11.33	N/A	$264.26	$13.91	N/A	$199.02	$10.48
You + Family	$196.60	$228.28	$12.02	$245.40	$284.94	$15.00	$181.60	$210.86	$11.10

IMPORTANT INFORMATION!

- You should read and understand SHBP's surcharge policy prior to making your health election for 2011
- The $80 Tobacco and $50 Spousal surcharges will apply to all retirees under age 65
- Intentional misrepresentation in response to surcharge questions will have significant consequences. You will lose State Health Benefit Plan coverage and will not be eligible to re-enroll

Spousal Surcharge

A $50 per month spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment, but chooses not to elect that coverage. You will automatically be charged the surcharge if you fail to answer all questions concerning the surcharge. The surcharge will apply to your premium for the 2011 Plan Year. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

Please note that SHBP may audit any member covering a spouse who does not pay the spousal surcharge.

Tobacco Surcharge

A $80 per month tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months or if you fail to answer these questions. The surcharge will apply to your premium for the 2011 Plan Year.

The tobacco surcharge may be removed by completing the tobacco cessation program requirements. Details are available at www.dch.georgia.gov/shbp. ***NOTE: No refunds for previously paid surcharges can be given.***

>> SECTION 2 - Retirees/Dependents who are not eligible for Medicare

STOP! IMPORTANT INFORMATION!

- It is important that you make an election this year to select your tier and to answer the surcharge questions. **If you do not answer the surcharge questions, the surcharges will be automatically charged to you**
- The OAP option will no longer be offered. If you have the OAP and do not make an election during the ROCP, SHBP will default your coverage to the HRA under the health care vendor you currently have
- See pages 3-5 for other Plan changes

Understanding Your Plan Options

If you change options or vendors during the year, any amounts applied toward your deductible or out-of-pocket are not transferred to the new option.

Health Maintenance Organization (HMO)

A HMO allows you to obtain benefits from participating providers statewide and on a national basis across the United States. You are not required to select a Primary Care Physician (PCP). HMOs provide 100 percent benefit coverage for preventive health care needs with no co-payments. Certain services are subject to a deductible and co-insurance when seeing an in-network provider. *See pages 8–11 for more information.*

Plan Features

- You do not have to obtain a referral to see a Specialist (SPC); however, you are encouraged to select a PCP to help coordinate your care
- Coverage is available only when using in-network providers (except in cases of emergencies)
- Co-payments do not count toward your deductible or out-of-pocket maximum

Health Reimbursement Arrangement (HRA)

The HRA is a Consumer Driven Health Plan option (CDHP) whose plan design offers you a different approach for managing your health care needs. This plan has a national network with in-network and out-of-network benefits. The SHBP funds dollar credits to your HRA each year to provide first dollar coverage for eligible health care and pharmacy expenses. Unused dollars in your HRA account roll over to the next Plan year if you are still participating in this option, but will be forfeited if you change options during the ROCP or due to a qualifying event.

Plan Features

- The plan offers unlimited wellness benefits based on national age and gender guidelines when seeing in-network providers only
- HRA dollar credits are part of this option only and can only be used with the HRA option
- The amount in your HRA is used to reduce the deductible and maximum out-of-pocket
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses
- Out-of-pocket limit includes covered prescription drugs

After satisfying your deductible, you will pay your co-insurance amount until you reach your out-of-pocket maximum.

- Certain drug costs are waived if SHBP is primary and you participate and remain compliant in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and/or Coronary Artery Disease
- If you enroll in this Plan after the 1st of the year, your HRA dollars are pro-rated but the deductibles are not

High Deductible Health Plan (HDHP)

The HDHP option offers in-network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. This Plan has a low monthly premium, and you must satisfy a high deductible that applies to all health care expenses except preventive care. **If you cover dependents, you must meet the ENTIRE deductible before benefits are payable for any covered member. You pay co-insurance after you have satisfied the deductible rather than set dollar co-payments for medical expenses and prescription drugs.** Also, you may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. HSAs typically earn interest and may even offer investment options. *See the Benefits Comparison chart that starts on page 8 to compare benefits under the HDHP to other Plan options.*

Plan Features

- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines when seeing an in-network provider
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire deductible for all medical expenses and prescriptions until the out-of-pocket maximum is met
- **This plan is not creditable. That means if you don't sign up for Medicare when you first become eligible; you may be charged a late enrollment penalty. See the legal notice for more information**

Health Savings Account (HSA) – Information Only

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may open an HSA with a bank or an independent HSA administrator/custodian.

You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan 2) Medicare 3) Medicaid; or 4) General Purpose Health Care Spending Account (GPHCSA) or any other non-qualified medical plan. SHBP does not offer an HSA account.

- You can contribute up to $3,050 single, $6,150 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, and over-the-counter medications when a doctor states they are medically necessary) that the IRS considers tax-deductible that are NOT covered by any health plan (see IRS Publication 502 at www.irs.gov)
- You can contribute an additional $1,000 if you are 55 or older (see IRS Publication 969 at www.irs.gov)
- Non-qualified distribution excise tax increases from 10 to 20%

HRA AND HSA CONSIDERATIONS

	HRA	HSA
Overview	A tax-exempt account that reimburses retirees and dependents for qualified medical expenses. Can be funded by employer only.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by retiree, employer, or other party.
Who is eligible?	Available to SHBP members enrolled in an HRA. See benefits chart for amounts funded by SHBP.	Available to SHBP members who elect HDHP and may enroll in an HSA of your choice.
Can I have other general medical insurance coverage and take advantage of this benefit?	Yes.	No.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The retiree.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Check with your HSA administrator.
If I terminate my SHBP coverage or change options...	Unused amounts can be distributed until depleted to pay for claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Covered Services					
Deductible/Co-Payments • You • You + Spouse • You + Child(ren) • You + Family	$1,300* $2,250* $2,250* $3,250* **HRA credits will reduce this amount*		$1,500 $3,000 $3,000 $3,000	$3,000 $6,000 $6,000 $6,000	$1,000 $1,500 $1,500 $2,000
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	$3,000* $5,000* $5,000* $7,000* **HRA credits will reduce this amount*		$2,400 $4,100 $4,100 $4,100	$5,300 $9,800 $9,800 $9,800	$3,000 $4,500 $4,500 $6,000
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$500 $1,000 $1,000 $1,500		None		None
Physicians' Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after a $35 PCP or $45 SPC per office visit co-payment
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams(these services are not subject to the deductible)	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible
Maternity Care (prenatal, delivery and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after initial $35 co-payment
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Physicians' Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	85% coverage; subject to in-network deductible		90% coverage; subject to in-network deductible		100% ($150 co-payment applies to facility expenses)
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% ($35 PCP or $45 SPC co-payment if billed as office visit)
Outpatient Surgery • When billed as outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% for shots and serum after a $35 PCP or $45 SPC per visit co-payment; no co-payment if office visit not billed
Hospital Services	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; not subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% after a $150 per visit co-payment; if admitted, co-payment waived; 80% subject to deductible
Outpatient Testing, Lab, etc.	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Non Routine laboratory; X-Rays; Diagnostic Tests; Injections—including medications covered under medical benefits—for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Behavioral Health	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 PCP or $45 SPC per visit co-payment. UHC $10 co-payment for group therapy
Dental	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC per visit co-payment; if inpatient/ outpatient facility, 80% subject to deductible
	NOTE: Notification required for all UHC options.				
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $45 SPC co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/ outpatient facility 80% subject to deductible
Vision	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Routine Eye Exam NOTE: Limited to one eye exam every 24 months	100% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered	100% after $45 SPC co-payment; not subject to deductible. $200 annual benefit for glasses and contacts
Other Coverage	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Hearing Services Routine hearing exam	85% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; not subject to the deductible		90% coverage for route exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; subject to the deductible		Not covered
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition	85% coverage; subject to deductible		90% coverage; subject to in-network deductible		100% coverage; not subject to deductible
Urgent Care Services NOTE: All subject to deductible except HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% after $35 co-payment

Benefits Comparison: HRA – HDHP – HMO

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Other Coverage	*The Plan Pays*		*The Plan Pays*		*The Plan Pays*
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; UHC up to 120 visits; CIGNA up to 120 days per Plan year
Skilled Nursing Facility Services NOTE: Prior approval required	85% coverage; up to 120 days per Plan year; subject to deductible	Not covered	90% coverage up to 120 days per Plan Year; subject to deductible	Not covered	80% coverage; up to 120 days per Plan year; subject to deductible
Hospice Care NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage when medically necessary
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services	85% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any out-of-network visits)	90% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)	100% coverage after $25 per visit co-payment; up to 40 visits per therapy per Plan year
Chiropractic Care NOTE: UHC Coverage up to a maximum of 20 visits; CIGNA – up to a maximum of 20 days, per plan year	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $35 PCP or $45 SPC co-payment per visit
Foot Care NOTE: Covered only for neurological or vascular diseases	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible	100% coverage after $35 PCP or $45 SPC co-payment per visit
Transplant Services NOTE: Prior approval required	Contact vendor for coverage details				
Pharmacy - You Pay					
Tier 1 Co-payment NOTE: No Tiers in HRA Option	15% generic; 25% brand; subject to deductible	40% generic; 40% brand; subject to deductible*	20% coverage; subject to deductible $10 min./ $100 max.	Not covered	$20
Tier 2 Co-payment Preferred Brand	Not applicable	Not applicable	20% coverage; subject to deductible $10 min./$100 max.	Not covered	$50
Tier 3 Co-payment Non-Preferred Brand	Not applicable	Not applicable	20% coverage; subject to deductible $10 min./$100 max.	Not covered	$90
Tier 4 Co-payment	Not applicable	Not applicable	Not Applicable	Not covered	Not applicable

What Should I Do Before I Make My 2011 Benefit Election?

- Evaluate your health care needs
- Carefully review the changes to SHBP options
- Compare the benefits under each option in relation to the premiums
- Verify your provider(s) will be participating in the option you choose
- Check the distance you will have to drive to see your provider(s)
- Check the Preferred Drug Lists to see if your prescriptions are covered and at what co-payment or co-insurance level
- If you currently have the HRA and change to the HDHP or HMO option, any unused HRA dollars will be forfeited

Who Should I Contact if I Have Benefit Questions?

- Contact CIGNA Retiree Line 800-942-6724
- UnitedHealthcare Retiree Line 877-246-4190

How Can I Make My 2011 Health Insurance Election?

Online

- You may go online at www.oe2011.ga.gov; 4 a.m. October 12 – 4:30 p.m. November 10
- If you are unable to access the site, contact SHBP for assistance at 800-610-1863 or 404-656-6322
- Make sure you select the correct option and tier you wish to have for the 2011 Plan Year
- Verify that you correctly answered the Tobacco and Spousal surcharge questions if they are presented
- Verify your dependents and make sure you add any eligible dependents under age 26 you wish to cover
- Remember to click CONFIRM to finalize your election
- Print or save your confirmation page
- Remember a confirmation number will be shown once your election has been processed. You should copy this number and keep it in a safe place
- Your election must be made by the end of the ROCP at 4:30 p.m. on November 10, 2010
- You may go online multiple times; however, the last option selected at the close of ROCP will be your option for 2011 unless you experience a qualifying event that allows you to make a change
- Please do not wait until the last minute. Web traffic and SHPB phone volumes are unusually heavy near the end of ROCP.

PLEASE READ!

If you complete both online and paper enrollment, it may result in you being placed in an incorrect option. Please do one or the other–not both

Paper

- Your Personalized Change Form is on the reverse side of the paper showing your address
- Check the option and tier that you choose for the 2011 Plan year
- Verify your dependents and make sure you add any eligible dependents under age 26 you wish to cover
- Verify you correctly answered the Tobacco and Spousal surcharge questions if they were presented
- Verify you corrected the address if it is incorrect
- Sign and date your Personalized Change Form
- Envelope must be postmarked by November 10, 2010 for your election to be valid

IMPORTANT REMINDERS

- The election you make during the ROCP is valid for the 2011 Plan year unless you experience a qualifying event which allows you to change options
- Be sure your address is kept current. All retiree communications from SHBP are through the United States mail to the address last provided by you
- Verify that the correct health deduction is taken from each retirement check if you are receiving an annuity
- If you want to cover a dependent under the age of 26, you must make the request during this ROCP
- Remember you only have 31 days before or after a qualifying event to add a dependent

>> SECTION 3 - What happens when I or a covered dependent become eligible for Medicare

General Medicare Information and SHBP Medicare Policy

Medicare is the country's health care system for individuals at age 65 or those with certain disabilities. When you or your dependent become eligible for Medicare because of reaching age 65 or disability, you should enroll in Medicare. Medicare includes Parts A - hospitalization, B - provider services and D - prescription drugs. You should enroll in Part A (if no cost to you) and Part B (monthly premium applies).

- You should enroll for Medicare when you first become eligible and should mail a copy of your Medicare card to SHBP, P.O. Box 1990, Atlanta, GA 30301 or fax to a secure fax line at 866-828-4796. To allow time for processing and to avoid paying higher premiums, you should submit this information by the first of the month prior to the month you turn age 65
- Members and/or their dependents eligible due to disability will be responsible for notifying SHBP of their Medicare enrollment as soon as they are eligible
- SHBP does not refund difference in premiums for non-timely submission of Medicare information
- SHBP will pay primary benefits on members not enrolled in Medicare but you will pay 100 percent of the cost of your SHBP premiums. Premiums will range from $1,000 to $2,400 per month
- Family members not eligible for the MA will keep their current option. This is called split eligibility

What if I Have End Stage Renal Disease (ESRD) ?

- If you have Medicare due to End Stage Renal Disease (ESRD), please send SHBP a copy of the notification from Social Security of your start date to P.O. Box 1990, Atlanta, GA 30301-1990. If you are under 65, eligible for Medicare due to ESRD, in your 30 month coordination period and wish to enroll in a Medicare Advantage option you must select the Humana option offered by SHBP through the CIGNA/Humana alliance. Both vendors can offer Medicare Advantage after the 30 month coordination period ends for ESRD.

Will My Options Change?

- Options are the same as active employees but you will also have the choice of two Medicare Advantage PPO plans
- When you or any of your eligible dependents (including dependent children) enroll in Medicare (because of reaching 65) the SHBP will automatically transfer the person (retiree or dependent) to the MA Standard Plan of your current health care vendor, if SHBP has the Medicare information on file
- Members age 65 or over eligible for a minimum of Medicare Part B but choosing not to enroll in one of the SHBP MA Plans will pay the entire cost of their health care premiums

Will My Premiums Change?

- Yes, when I or a covered dependent become eligible for Medicare
- Premiums will change for all options
- Please refer to the SHBP rate sheets for premiums

You should carefully read section 4 for detailed information about the impact Medicare will have on your coverage and plan options.

>> SECTION 4 - Retiree Benefits when I am, or a covered dependent is, eligible for Medicare

>> Changes for Medicare Eligible Retirees Under Age 65

STOP! IMPORTANT INFORMATION!

- $80 Tobacco and $50 Spousal surcharges will apply to retirees under 65 with Medicare who do not elect to enroll in one of the MA PPO plans
- The OAP Option will no longer be offered. If you have the OAP and do not make an election during the ROCP, SHBP will default your coverage to the HRA under the health care vendor you currently have
- If you or the Medicare eligible dependent are under age 65, you are not required to enroll in one of the MA PPO options. You will pay the same rate as active members, regardless of Medicare enrollment and you will also be subject to the Tobacco and Spousal surcharges
- You will not receive a discount for any parts of Medicare you may have
- If SHBP is paying the Late Enrollment Penalty (LEP) for Medicare Part B, continued payment of the LEP will apply only to MA PPO enrolled members. Enrollment in any of the other options will result in discontinuation of the LEP payment by SHBP
- See pages 3-5 for other Plan changes

See pages 6-7 for information about your plan options and pages 8-11 for a Benefits Comparison Chart of each option.

IF UNDER 65 WITH MEDICARE	
Options	**HRA, HMO, HDHP and MA**
If not enrolled in MA	• Pay active rate • Subject to surcharges • No discount for any parts of Medicare you are enrolled

IF UNDER 65 WITH MEDICARE due to ESRD	
Options	**HRA, HMO, HDHP and MA**
If in the 30 month coordination period	• May enroll in MA with Humana
If the 30 month coordination period has been met	• May enroll in MA with Humana or UnitedHealthcare

Who Should I Contact if I Have Benefit Questions?

- Contact CIGNA Retiree Line 800-942-6724
- UnitedHealthcare Retiree Line 877-246-4190

DANGER!

- If you stop paying for your Medicare Part B, your coverage under the MA PPO will be discontinued and you will be moved to an unsubsidized option and pay the full cost of the health insurance
- Individuals who enroll in one of the MA PPO options will receive the state contribution toward the cost of health insurance premiums
- Individuals who enroll in one of the SHBP non-MA PPO options will not receive the state contribution toward the cost of health insurance
- If you enroll in Medicare Part D after enrolling in the MA PPO, you will lose your SHBP coverage permanently

What Should I Do Before I Make My 2011 Benefit Election?

- Evaluate your health care needs
- Carefully review the changes to the SHBP options
- Compare the benefits under each option in relation to the premiums
- Verify your provider(s) will be participating in the option you choose
- Check the distance you will have to drive to see your provider(s)
- Check the Preferred Drug Lists to see if your prescriptions are covered and at what co-payment or co-insurance level
- If you currently have the HRA and change to the HDHP or HMO option, any unused HRA dollars will be forfeited
- Check to see if you have any dependents that you wish to cover, under the age of 26, that may be eligible for SHBP coverage. You have only this one opportunity to add a newly eligible dependent to your retiree coverage

How Can I Make My 2011 Health Insurance Election?

Online

- You may go online at www.oe2011.ga.gov; 4 a.m. October 12 – 4:30 p.m. November 10
- If you are unable to access the site, contact SHBP for assistance at 800-610-1863 or 404-656-6322
- Make sure you select the correct option and tier you wish to have for the 2011 Plan year
- Verify you correctly answered the Tobacco and Spousal surcharge questions if they were presented
- Remember to click CONFIRM to finalize your election
- Remember a confirmation number will be shown once your election has been processed. You should copy this number and keep it in a safe place
- Your election must be made by the end of the ROCP at 4:30 p.m. on November 10, 2010
- You may go online multiple times; however, the last option selected at the close of ROCP will be your option for 2011 unless you experience a qualifying event that allows you to make a change
- Please do not wait until the last minute. Web traffic and SHPB phone volumes are unusually heavy near the end of ROCP.

PLEASE READ!

If you complete both online and paper enrollment, it may result in you being placed in an incorrect option. Please do one or the other–not both

Paper

- Your Personalized Change Form is on the reverse side of the paper showing your address
- Check the option and tier that you choose for the 2011 Plan year
- Verify your dependents and make sure you add any eligible dependents under age 26 you wish to cover
- Verify you correctly answered the Tobacco and Spousal surcharge questions if they were presented
- Verify you corrected the address if it is incorrect
- Sign and date your Personalized Change Form
- Envelope must be postmarked by November 10, 2010 for your election to be valid
- You should complete the Newly Eligible Dependent Child Form if applicable

>> Changes for Medicare Eligible Retirees 65 and Older

STOP! IMPORTANT INFORMATION!

Tier Changes

- Retirees will have the same tiers as active employees. They are:
  ■ You ■ You + Spouse
  ■ You + Child(ren) ■ You + Family*

Late Enrollment Penalty

- If SHBP is paying the Late Enrollment Penalty (LEP) for Medicare Part B, payment of the LEP will apply only to MA PPO enrolled members. Enrollment in any of the other options will result in discontinuation of payment of the LEP by SHBP

Medicare Advantage PPO Plans replace Private Fee for Service Plans

- The Centers for Medicare & Medicaid Services are requiring that national Medicare Advantage Private Fee for Service (MA PFFS) plans offer a network effective January 1, 2011. Therefore, SHBP will be offering Medicare Advantage (MA) PPO plans. These plans will replace the (MA) PFFS plans. The new MA Preferred Provider Organization (PPO) plan will have many of the same features as the PFFS plan and you will continue to have your choice between the Standard and Premium plan from both health care vendors, but with some important changes:

  —No more deeming! The new MA PPO plans offer a national contracted network. Also, you have the option of seeing non participating providers as long as they accept Medicare

  —Unlike traditional PPO plans, there is no difference in your co-payment/co-insurance levels if you see providers who are contracted (in-network) or providers who are not contracted (out-of-network) as long as the provider accepts Medicare. You are not penalized for going to a non-contracted provider

  —There is no coverage if you see a provider who does not accept Medicare

  —See other changes on page 17

CIGNA and Humana Alliance

- CIGNA and Humana have formed an alliance to offer the new MA PPO plans. Effective January 1, 2011, the Humana PPO plans will replace the CIGNA MA PFFS plans currently offered. The materials you will receive will reference the Humana Group Medicare PPO Plans. Your ID card will also show the Humana Group Medicare Plans

*Family means you + spouse + children

Other Medicare Advantage PPO Differences

Basically the benefits are the same as under the Medicare Advantage Private Fee for Service Plans with the following exceptions:

	STANDARD		PREMIUM	
Benefit Change	**2010**	**2011**	**2010**	**2011**
Out-of-Pocket Maximum	$1,000	$2,000	$500	$1,000
Inpatient Hospital Services (includes Mental Health and Substance Abuse Inpatient Facility	$190 co-payment days 1-4	$190 co-payment days 1-6	$100 co-payment days 1-3	$100 co-payment days 1-5
Outpatient Specialized Scans	$95 co-payment	85% coverage	$50 co-payment	90% coverage
Annual Physicals	$20 PCP or $25 SPC co-payment	$0 co-payment	$10 PCP or $20 SPC co-payment	$0 co-payment
Mental Health and Substance Abuse Outpatient Visits	$25 per office visit co-payment	No change	$10 per office visit co-payment	$20 per office visit co-payment
Durable Medical Equipment (DME)	90% coverage for Medicare covered items (no prior approval required)	85% coverage for Medicare covered items (no prior approval required)	90% coverage for Medicare covered items (no prior approval required)	No change
Co-Payments	Did not apply to Maximum Out-of-pocket	Apply to Maximum Out-of-pocket except for pharmacy	Did not apply to Maximum Out-of-pocket	Apply to Maximum Out-of-pocket except for pharmacy
Pharmacy	**2010**	**2011**	**2010**	**2011**
Tier 1 Co-payment	$10 retail; $20 mail order – 90 day supply	No change	$10 retail; $20 mail order – 90 day supply	No change
Tier 2 Co-payment	$25 retail; $50 mail order – 90 day supply	$40 retail; $80 mail order – 90 days supply	25% up to max of $25; mail order – 25% not to exceed $50	$30 retail; $60 mail order – 90 day supply
Tier 3 Co-payment	$50 retail; $100 mail order – 90 day supply	$80 retail; $160 mail order – 90 day supply	25% up to max of $50; mail order – 25% not to exceed $100	$60 retail; $120 mail order – 90 day supply
Tier 4 Co-payment	$50 retail; $100 mail order – 90 day supply	$80 retail; $160 mail order – 90 day supply	25% up to max of $50; mail order – 25% not to exceed $100	$60 retail; $120 mail order – 90 day supply

What is the New Medicare Advantage PPO Plan?

The Medicare Advantage Preferred Provider Organization (MA PPO) plan is an approved plan by the Centers for Medicare & Medicaid (CMS); sometimes called a Part C Plan. This plan takes the place of your original Medicare Part A – Hospital, B – Medical and includes Medicare Part D prescription drug benefit. This plan is very similar to a traditional PPO plan. You may receive benefits from in-network and out-of-network providers. The MA PPO also provides a contracted network on a statewide and national basis across the United States. You will have the choice of a MA PPO Standard or Premium Plan. Plus, you can see non-contracted providers as long as they accept Medicare.

- You do not have to select a primary care physician (PCP) or obtain a referral to see a specialist
- Co-payments apply toward the out-of-pocket maximum (except for prescription drugs)
- Unlike traditional PPO plans, there is no difference in your co-payment/co-insurance levels if you see providers who are contracted (in-network) or providers who are not contracted (out-of-network). So, you are not penalized for going to a non-contracted provider
- There will be no coverage if you see a provider who does not accept Medicare
- Enrollment in the MA PPO plans is subject to CMS approval
- SHBP must have your street address and Medicare number (including the letter at the end of the Medicare number) for CMS to approve
- Once approved, CMS will notify SHBP of the effective date of your coverage
- You will receive a new insurance card that you will show (in place of your Medicare card) when receiving service

When everyone you cover is not eligible to participate in the MA PPO option, it is called split eligibility. This means that the individual with Medicare enrolls in the MA PPO option and any family members that are not eligible for Medicare because of age or disability, can enroll in one of the other options offered by SHBP with the same vendor as the retiree.

Prescription Drug Coverage Under the Medicare Advantage Plan

- The Plan includes Medicare Part D coverage
- Once you reach the out-of-pocket costs of $4,550, you will pay the greater of 5 percent co-insurance of the cost of the drug or $2.50 for generic drugs or a drug that is treated like a generic, or a $6.30 co-payment for all other drugs

What are my 2011 SHBP Plan Options if I Want the State to Contribute to My Premiums?

- Humana Group Medicare PPO Plan – Standard (through Alliance with CIGNA)
- Humana Group Medicare PPO Plan – Premium (through Alliance with CIGNA)
- UnitedHealthcare Group Medicare Advantage PPO Plan – Standard
- UnitedHealthcare Group Medicare Advantage PPO Plan – Premium

If 65 or older with Medicare	Then...
Stop Paying Part B	SHBP will move you to the option you had before MA and you will pay 100 percent of the premium; if the option is not offered, you will be placed in the HRA
Enroll in a non-SHBP MA Plan after enrolling in SHBP MA Plan	• Your coverage under SHBP will be terminated • If your dependent enrolled in another plan – change to single for retiree and dependent loses SHBP coverage
Enroll in an individual Prescription Drug Plan	• Your coverage under SHBP will be terminated • If your dependent enrolled in another plan – change to single for retiree and dependent loses SHBP coverage
If 65 with no Part B	• Keep option from last year unless (OAP) and pay 100% of cost • If you don't make an election during ROCP, default to HRA option
Have ESRD and over 65 (subject to CMS rules)	• During the initial 30 month period, SHBP will pay primary benefits • When 30 month period is exhausted, may enroll in MA and receive State contribution to premium • If you don't enroll in a MA you will pay 100 percent of cost of premium

DANGER!

- You cannot enroll in a SHBP MA option telephonically in 2011. If you do, you have enrolled in an individual plan and will permanently lose your SHBP coverage
- If you stop paying your Medicare Part B premium, you will lose your SHBP MA PPO option and SHBP will move you to the HRA option. You will pay 100 percent of the cost of the premium
- Do not enroll in a separate Medicare Part D plan as you will permanently lose your SHBP coverage
- If you enroll in a non-SHBP Medicare Advantage plan, you will permanently lose your SHBP coverage
- **Disregard any information that is not in an envelope from SHBP, CIGNA, Humana or UnitedHealthcare that says for "State Health Benefit Plan Retirees"**
- Should you drop your SHBP MA PPO coverage during the year, your original Medicare (A and B) will automatically go into effect. You will have a special enrollment period of 63 days from the date your coverage was lost to elect a Medicare Part D plan without penalties applying **BUT YOUR SHBP COVERAGE IS PERMANENTLY GONE**

If you or your covered dependent(s) have Part A but do not have Part B, you should contact Social Security for information on enrolling during the general enrollment period of January 1 through March 31 each year.

What Should I Do Before I Make My 2011 Benefit Election?

- Evaluate your health care needs
- Carefully review the changes to the SHBP options
- Compare the benefits under each option in relation to the premiums
- Verify your provider(s) will be participating in the option you choose
- Check the distance you will have to drive to see your provider(s)
- Check the Preferred Drug Lists to see if your prescriptions are covered and at what co-payment or co-insurance level
- SHBP will default your coverage to the current health care vendor and the Standard or Premium option you have if you do not make an election during the ROCP
- Remember there are now four tiers; determine if it will impact you
- Remember the Tobacco and Spousal surcharges do not apply to retirees and their dependents that are enrolled in a MA PPO or split option
- There is no additional benefit for members having State on State coverage

Who Should I Contact if I Have Benefit Questions?

- Contact CIGNA/Humana Retiree Line 800-942-6724
- UnitedHealthcare Retiree Line 877-246-4190

Changing Options and Have the HRA

- If you have a balance of $10 or more in your HRA at the time you move to the MA PPO, an individual HRA account will be set up by your health care vendor
- After a six month run out period, to allow for prior year's claims, the funds will be available for use
- In July or August, UHC will pay the member monies in the HRA in the amount for any co-payments, deductible or co-insurance to the maximum balance in the HRA that you may have paid. If you are a CIGNA – Humana member, you will need to submit a claim for the co-payments, deductible or co-insurance in July or August for which you have paid. The claim form is available at www.dch.georgia.gov/shbp

How Can I Make My 2011 Health Insurance Election?

Online

- You may go online at www.oe2011.ga.gov; 4 a.m. October 12 – 4:30 p.m. November 10
- If you are unable to access the site, contact SHBP for assistance at 800-610-1863 or 404-656-6322
- Make sure you select the correct option and tier you wish to have for the 2011 Plan year
- Verify your dependents and make sure you add any eligible dependents under age 26 you wish to cover
- Remember to click CONFIRM to finalize your election
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Paper

- Your Personalized Change Form is on the reverse side of the paper showing your address
- Check the option and tier that you choose for the 2011 Plan year
- Verify your dependents and make sure you add any eligible dependents under age 26 you wish to cover
- Verify you correctly answered the Tobacco and Spousal surcharge questions if they were presented
- Verify you corrected the address if it is incorrect
- Sign and date your Personalized Change Form
- Envelope must be postmarked by November 10, 2010 for your election to be valid
- You should complete the Newly Eligible Dependent Child Form if applicable

IMPORTANT REMINDERS

- **If you are not enrolling in one of the MA PPO options, you will not be able to make your election online. You will need to complete the Personalized Change Form. The form will be in your Retiree Option Change Packet**
- **Remember you only have 31 days before or after a qualifying event to add a dependent.**

Benefits Comparison: SHBP Medicare Advantage with Prescription Drugs PPO Standard and Premium Plans

Schedule of Benefits for You and Your Dependents for January 1, 2011 – December 31, 2011

	STANDARD SHBP MA PPO	PREMIUM SHBP MA PPO
	Humana, UnitedHealthcare	Humana, UnitedHealthcare
Covered Services	*You Pay*	*You Pay*
Maximum Lifetime Benefit (combined for all SHBP Options)	Not applicable	Not applicable
Pre-Existing Conditions (First year in Plan only, subject to HIPAA)	Not applicable	Not applicable
Lifetime Benefit Limit for Treatment of • Temporomandibular joint dysfunction (TMJ)	Contact plans for details	Contact plans for details
Deductibles	Not applicable	Not applicable
Out-of-Pocket Maximum Per Member	$2,000 per member	$1,000 per member
Physicians' Services	*You Pay*	*You Pay*
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	PCP—$20 per office visit co-payment; SPC—$25 per office visit co-payment	PCP—$10 per office visit co-payment; SPC—$20 per office visit co-payment
Primary Care Physician or Specialist Office or Clinic Visits Annual routine physical exam (non-Medicare covered)	$0 co-payment	$0 co-payment
Annual Screenings	$0 co-payment; (mammograms, pap smears, prostate cancer screening, colorectal cancer screening)	$0 co-payment; (mammograms, pap smears, prostate cancer screening, colorectal cancer screening)
Inpatient Hospital Services	$190 co-payment per day for days 1-6; $0 co-payment per day for days 7 and beyond	$100 co-payment per day for days 1-5; $0 co-payment per day for days 6 and beyond
Outpatient Hospital Services (includes observation, medical and surgical care)	$95 co-payment per surgery	$50 co-payment per surgery
Outpatient Standard (X-rays, Lab and Diagnostic Tests)	$0 co-payment	$0 co-payment

Benefits Comparison: SHBP Medicare Advantage with Prescription Drugs PPO Standard and Premium Plans

Schedule of Benefits for You and Your Dependents for January 1, 2011 – December 31, 2011

	STANDARD SHBP MA PPO	PREMIUM SHBP MA PPO
	Humana, UnitedHealthcare	Humana, UnitedHealthcare
Behavioral Health	*You Pay*	*You Pay*
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Mental Health lifetime max does not apply when admitted to a psychiatric unit of a general hospital	$190 co-payment per day for days 1–6, $0 co-payment for days 7–190; 190 day lifetime maximum when admitted to a psychiatric hospital; $60 co-payment per day for partial hospitalization	$100 co-payment per day for days 1–5, $0 co-payment for days 6–190; 190 day lifetime maximum when admitted to a psychiatric hospital; $50 co-payment per day for partial hospitalization
Mental Health and Substance Abuse Outpatient Visits	PCP–$20 per office visit co-payment; SPC–$25 per office visit co-payment	PCP–$10 per office visit co-payment; SPC–$20 per office visit co-payment
Dental	*You Pay*	*You Pay*
Dental and Oral Care Medicare covered	$25 per office visit co-payment for Medicare covered dental services	$20 per office visit co-payment for Medicare covered dental services
Vision	*You Pay*	*You Pay*
Routine Eye Exam NOTE: Limited to one eye exam every 12 months	$25 co-payment per office visit—limited to 1 annual eye exam; $125 eyewear (glasses or contact lenses and frames) allowance every 24 months	$20 co-payment per office visit—limited to 1 annual eye exam; $125 eyewear (glasses or contact lenses and frames) allowance every 24 months
Other Coverage	*You Pay*	*You Pay*
Routine Hearing Services	$25 co-payment limited to one test every 12 months; $1,000 hearing aid allowance every 48 months	$20 co-payment limited to one test every 12 months; $1,000 hearing aid allowance every 48 months
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition	$0 co-payment	$0 co-payment
Urgent Care Services	$25 co-payment waived if admitted to hospital within 24 hours for the same condition	$20 co-payment waived if admitted to hospital within 24 hours for the same condition
Other Coverage	*You Pay*	*You Pay*
Home Health Care Services	$0 co-payment per visit	$0 co-payment per visit
Emergency Care	$50 co-payment waived if admitted to hospital within 24 hours for the same condition	$50 co-payment waived if admitted to hospital within 24 hours for the same condition

Benefits Comparison: SHBP Medicare Advantage with Prescription Drugs PPO Standard and Premium Plans

Schedule of Benefits for You and Your Dependents for January 1, 2011 – December 31, 2011

	STANDARD SHBP MA PPO	PREMIUM SHBP MA PPO
	Humana, UnitedHealthcare	Humana, UnitedHealthcare
Other Coverage	*You Pay*	*You Pay*
Skilled Nursing Facility Services	$0 co-payment per day for days 1–10; $50 co-payment per day for days 11–100 for up to 100 days per benefit period (no prior hospital stay required)	$0 co-payment per day for days 1–10; $25 co-payment per day for days 11–100 for up to 100 days per benefit period (no prior hospital stay required)
Hospice Care	100% coverage; (must receive care from a Medicare covered hospice facility; no prior approval required)	100% coverage; (must receive care from a Medicare covered hospice facility; no prior approval required)
Durable Medical Equipment (DME)	85% coverage for Medicare covered items (no prior approval required)	90% coverage for Medicare covered items (no prior approval required)
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services	$25 co-payment per office visit for Medicare covered services; no limit on number of visits	$10 co-payment per office visit for Medicare covered services; no limit on number of visits
Chiropractic Care	Medicare Covered Humana-$25; UnitedHealthcare-$18 co-payment per office visit; Routine Non-Medicare Covered-Humana/UnitedHealthcare $25 co-payment per office visit; limit of 20 visits per year	Medicare Covered Humana-$20; UnitedHealthcare-$18 co-payment per office visit; Routine Non-Medicare Covered and Humana/UnitedHealthcare-$20 co-payment per office visit; limit of 20 visits per year
Foot Care	$20 PCP-$25 SPC per office visit co-payment; Routine Non-Medicare Covered-$25 co-payment, limit of 6 visits per year	$10 PCP-$20 SPC per office visit co-payment; Routine Non-Medicare Covered-$20 co-payment; limit of 6 visits per year
Transplant Services NOTE: Prior approval required	$190 co-payment per day for days 1–6; $0 co-payment per day for days 7 and beyond	$100 co-payment per day for days 1–5; $0 co-payment per day for days 6 and beyond
Pharmacy	*You Pay*	*You Pay*
Tier 1 Co-payment	*$10 retail; $20 mail order—90-day supply	*$10 retail; $20 mail order—90-day supply
Tier 2 Co-payment	*$40 retail; $80 mail order—90-day supply	$30 retail; $60 mail order—90-day supply
Tier 3 Co-payment	*$80 retail; $160 mail order—90- day supply	$60 retail; $120 mail order—90-day supply
Tier 4 Co-payment NOTE: UHC includes specialty	*$80 retail; $160 mail order— 90-day supply; Medicare Part B Covered Drugs—85% coverage	$60 retail; $120 mail order—90-day supply Medicare Part B covered drugs–90% coverage
Tier 5 Co-payment (Humana only) Specialty Drugs	Contact Humana	Contact Humana

*After your yearly out-of-pocket cost reaches $4,550, you will pay the greater of $2.50 for the generic or a preferred brand drug that is a multi-source drug and $6.30 for all other drugs, or 5% co-insurance.

>> SECTION 5 - Health & Wellness

What Can You Do About Your Health?

Take a Personal Health Assessment at least once a year to assist you in learning about potential health risks related to your lifestyle. Each vendor has a health assessment questionnaire available on their website that you can complete. After completing the health assessment you will get a customized report that identifies health risks and provides recommendations on ways to help you reduce health risks and suggestions on how to make better lifestyle choices. Members who complete the health assessment may be contacted by the vendor's registered nurses or health coaches regarding steps they can take to control or eliminate these risks. **Participant data is completely confidential and individual results are not shared with your employer or SHBP.**

Utilize the Preventive Health and Wellness services. One of the best ways to stay healthy is to take advantage of preventive health care. Check with the vendor regarding the plan option you choose to confirm which preventive services are covered. In addition, each vendor offers health coaching and wellness programs such as weight loss, nutrition, stress management and smoking cessation. Contact the vendors to learn more about the programs they offer or visit their website to view available services.

CMS guidelines require health care vendors reach out to members enrolled in a MA PPO option via telephone to complete a Health Assessment. This assessment may be completed on paper.

Engage in the Health Management Services. Each vendor offers assistance with health care services including disease management, case management and behavioral health.

Call the Nurse Advice Line. Each vendor has a 24-hour; seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. Check with your health plan option for the telephone number.

DID YOU KNOW?

Good health is priceless. When you live a healthy lifestyle, you can feel better; live easier and save money on health care expenses!

>> SECTION 6 - SHBP Eligibility

The SHBP covers dependents who meet SHBP guidelines. Eligibility documentation must be submitted before SHBP can send notification of a dependent's coverage to the health care vendors.

Eligible Dependents Are:

1. **Spouse** – Individual who is not legally separated, who is of the opposite sex to the Enrolled Member and who is legally married or who submits satisfactory evidence to the Administrator of common law marriage to the Employee or Retiree entered into prior to January 1, 1997 and is not legally separated.
2. **Dependent Child** – An eligible Dependent child of an Enrolled Member must meet one of the following definitions:
   - **Natural child** – A natural child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Adopted child** – Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Stepchild** – Eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the stepchild loses his or her status as stepchild of the Enrolled Member, whichever is earlier.
   - **Guardianship** – A child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date the legal guardianship is established. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to establish legal guardianship and that other legal papers present undue hardship on the Member or living natural parent(s).
   - **Totally Disabled Child** – A natural child, legally adopted child or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized, and depends primarily on the Enrolled Member for support and maintenance.

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, provided you request the change within 31 days of the qualifying event. Also, your requested change must correspond to the qualifying event. For a complete description of qualifying events, see your Summary Plan Description. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322.

Qualifying events include, but are not limited to:

- Birth or adoption of a child, or placement for adoption
- Change in residence by you or your spouse that results in ineligibility for coverage in your selected option because of location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

IMPORTANT INFORMATION!

- Please submit your change request, within 31 days of the qualifying event to SHBP. Requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate
- SHBP will accept dependent verification at anytime during the plan year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **Spouse** – Certified copy of marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse)including legible signatures for you and your spouse with financial information blacked out. The spouse's Social Security Number is also required
- **Natural or adopted child –** Certified copy of birth certificate or birth card issued by hospital which lists parents by name are accepted for new births and certified copy of court documents establishing adoption and stating date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If a certified copy of the birth certificate is not available for an adopted child, other proof of the child's date of birth is required. The Social Security Number is required for all children two and older
- **Stepchild** – Certified copy of birth certificate showing your spouse is the natural parent of the child AND certified copy of marriage license showing the natural parent of the child is your spouse or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The Social Security Number is required for all children age two and older
- **Legal Guardianship** – Certified copy of court documents establishing the legal guardianship and stating the dates on which the guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth. The Social Security Number is required for all children age two and older

PLEASE READ!

No health claims will be paid until the documentation is received and approved by SHBP.

The member's Social Security Number MUST be written on each document so we can match your dependents to your record. Do not send originals as they will not be returned.

COBRA Rights – Dependents of Retirees

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer your spouse or an eligible dependent the opportunity to continue health coverage if Plan coverage is lost due to a Qualifying Event. The length of time one of your dependents may continue the coverage is based on the Qualifying Event. For further information refer to your SPD.

>> SECTION 7 - Legal Notices

About the Following Notices

The notices on the following pages are required by the Center for Medicaid & Medicare Services (CMS) to explain what happens if you buy an individual Medicare Prescription Drug (Part D) Plan. The chart below explains what happens if you buy an individual Medicare Part D Plan.

Your SHBP Option	What happens if you buy an individual Medicare Part D Plan
SHBP Medicare Advantage PPO Standard or SHBP Medicare Advantage PPO Premium Plan	You will permanently lose SHBP coverage if you purchase a Part D Plan once enrolled in a SHBP Medicare Advantage Plan. You will not pay a Medicare "late enrollment" penalty
HRA /HMO	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the Out-of-pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will not pay a Medicare "late enrollment" penalty
HDHP (High Deductible)	You will have to pay a Medicare "late enrollment" penalty if you miss the initial enrollment period because the HDHP option is not considered "creditable coverage"

These notices state that prescription drug coverage under all SHBP coverage options except for the HDHP (High Deductible) option is considered Medicare Part D "creditable coverage." This means generally that the prescription drug coverage under SHBP MA Standard, SHBP MA Premium, HMO and HRA are all "as good or better than" the prescription drug coverage offered through Medicare Part D plans that are sold to individuals.

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

Important Notice from the SHBP about Your HDHP Prescription Drug Coverage and Medicare

About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare High Deductible Health Plan (HDHP) and Medicare

For Plan Year: January 1 – December 31, 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three (3) important things you need to know about your current coverage and Medicare's prescription drug coverage:

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2 The SHBP has determined that the prescription drug coverage offered by the HDHP option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP offered by SHBP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3 You can keep your current coverage in a CIGNA or UnitedHealthcare HDHP offered by the SHBP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and costs of the plans offering Medicare Prescription Drug Coverage in your area. *Read this notice carefully as it explains your options.*

When Can you Join a Medicare Drug Plan?

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you decide to drop your current coverage under SHBP, since it is an employer sponsored group plan; you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug Plan; However, you also may pay a higher premium (a penalty) because you did not have Creditable Coverage under SHBP.

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When will you pay a Higher Premium (a Penalty) to Join a Medicare Drug Plan?
Since the HDHP coverage under SHBP, is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have coverage. For example, if you go nineteen months without creditable coverage, your premium may be consistently 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens to Your Current Coverage if you Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current HDHP coverage under SHBP will be affected. If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage and the HDHP will coordinate benefits with the Part D coverage. If you decide to join a Medicare Drug Plan and drop your HDHP coverage under SHBP, be aware that be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

You should also know that if you drop or lose your HDHP coverage with SHBP and don't join a Medicare Drug Plan with 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

For more information about this notice or your current prescription drug coverage...
Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug coverage, and if this coverage through SHBP changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call (1-877-486-2048). 24 hours a day/7 days a week

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at (1-800-772-1213). TTY users should call (1-800-325-0778).

Date: October 1, 2010
Name of Entity/Sender: State Health Benefit Plan
Contact: Call Center
Address: P.O. Box 1990, Atlanta, GA 30301
Phone Number: 404-656-6322 or 800-610-1863

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

Important Notice from the SHBP About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare HMO, HRA and Medicare

For Plan Year: January 1 – December 31, 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to learn about your current coverage and Medicare's prescription drug coverage:

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2 The SHBP has determined that the prescription drug coverage offered by the CIGNA and UnitedHealthcare HMO and HRA offered under SHBP is, therefore, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Do Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage the month following receipt of enrollment notice. You should send a copy of your Medicare cards to SHBP at P.O. Box 1990, Atlanta, GA 30301.

If you do join a Medicare drug plan and drop your coverage with SHBP, be aware that you and your dependents can not get this coverage back if you are a retiree.

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your SHBP Current Prescription Drug Coverage...
Contact the SHBP Eligibility Unit at 404-656-6322 or 800-610-1863. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage, through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. 24 hours a day/7 days a week

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2010
Name of Entity/Sender: State Health Benefit Plan
Contact: Call Center
Address: P. O. Box 1990, Atlanta, GA 30301
Phone Number: 404-656-6322 or 800-610-1863

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

NOTES

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Common Acronyms

CDHP – Consumer Driven Health Plan

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

MA (PPO) – Medicare Advantage Preferred Provider Organization

PCF – Personalized Change Form

PCP – Primary Care Physician

ROCP – Retiree Option Change Period

SHBP – State Health Benefit Plan

SPC – Specialist

SPD – Summary Plan Description

UHC – UnitedHealthcare

Georgia Department of
Community Health